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March 1, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Comments on CY 2024 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies

Dear Administrator Brooks-LaSure,

PNHP welcomes CMS' efforts to begin to rein in abuse of the payment system by Medicare Advantage (MA) plans and rampant overpayments to the plans from CMS, which up to this point has been extensive and threatens the solvency of the Medicare Trust Fund.^{1,2} Accountability to both Medicare beneficiaries and taxpayers instead of to investors and corporate greed is long overdue. We encourage CMS not to give in to industry lobbying pressure, and to implement the proposed changes without compromising, and we believe even stronger measures are needed. After all, it is the mission of CMS to protect the integrity of the Medicare program.

We speak as advocates for a universal national health program which would be as cost-effective as possible, and we believe this could be constructed as an improved form of Traditional Medicare. The long unbroken record of gaming the payment system and overpayments to MA plans without evidence for improved outcomes (and easily gamed quality metrics do not qualify as evidence of improvement) point to the folly of expecting capitated fiscal intermediaries to reduce Medicare cost.³ The track record of MA is antithetical to the "Triple Aim" goals of improved quality of care, improved population health, and reduced cost.

The profitability of MA plans has rested heavily on gaming strategies and fraud. Their strategies include gaming their risk pools by marketing to the healthy and discouraging the sick from enrolling, and by encouraging beneficiaries to disenroll once they develop expensive chronic conditions by making their care as frustrating as possible.⁴ CMS attempted to correct risk pool gaming with risk adjustment via the Hierarchical Condition Categories (HCC) formula, but this tied diagnosis to payment and opened the door to up-coding as a new gaming strategy, which has become widespread among MA plans, as CMS is well aware.⁵ CMS is also aware of extensive evidence that MA plans use proprietary prior authorization policies to deny care that meets Medicare medical necessity criteria.⁶

The proposed changes include cracking down on deceptive marketing practices and restricting prior authorizations to ensure that they are appropriate and timely and issued only after review by a physician with the appropriate specialty or sub-specialty training. The new rules would require all MA plans to establish utilization management committees to review prior authorization policies annually to ensure consistency with Medicare coverage decisions and guidelines. They also require adequate networks of behavioral health and substance abuse providers. However, we are concerned that up to now CMS has not had the resources to enforce such requirements, and when plans claim "network adequacy," "secret

shopper” surveys have found that a high percentage of “network” providers are not actually accepting new patients with that plan. We urge CMS to resist industry pressure and not only follow through with imposing the new rules, but to ensure adequate resources to enforce them as well.

The new rules for MA plans also include changes to the HCC risk adjustment formula to eliminate codes that are commonly up-coded and place caps on upcoding. We also applaud CMS’ audits of coding practices and recoupment of billions in overpayments to MA plans over the past several years. These measures are much needed, but the MA plans are highly motivated to continue to exploit upcoding. They will apply intense lobbying pressure to water down the changes, and the proposed rule changes may not be adequate to stop coding abuse. We encourage CMS to hold firm in implementing the new rules and deploy the resources necessary to enforce them.

Although the proposed rule changes may be helpful in restricting fraud and abuse by MA plans, we recommend that CMS consider the more effective measures recommended in the letter from Rep. Pramila Jayapal and 69 co-signers to President Biden, HHS Secretary Becerra, and CMS Administrator Brooks-LaSure dated Feb. 16, 2022. These include:

- 1) Strongly enforce the proposed rules prohibiting MA plans from imposing any additional clinical criteria for prior authorization approvals outside of current Medicare coverage policies, and ban step-therapy policies. Research has shown that prior authorization and step-therapy policies for Medicare Part B are associated with higher health costs, hospitalizations, and office visits, so there is no justification for continuing these destructive policies.
- 2) Require MA plans to cover services from any medical provider that accepts Medicare’s approved rate. This would end networks that unreasonably restrict access to necessary care. Plans claim their networks assure quality providers, but in reality they serve the goal of restricting access to care so as to drive beneficiaries with more costly conditions out of the plan, a “lemon dropping” strategy used to game the plan’s risk pool.
- 3) Implement stronger measures to curb up-coding, as CMS’s proposal to use the statutory minimum coding intensity adjustment of 5.9 percent for 2023 is inadequate to keep up with increased upcoding by MA plans. Jayapal’s letter recommends using the Demographic Estimate of Coding Intensity (DECI) risk adjustment scheme to correct for up-coding under the HCC system. However, we believe this, too, would be inadequate unless 1) and 2) above were implemented and enforced, because even if the rules substantially reduced up-coding, that would not eliminate “lemon dropping” sicker, more expensive beneficiaries within a diagnostic category by making their care as frustrating as possible, or evicting doctors who care for more expensive illnesses from the plan’s network.

All the problems with fraud and abuse via gaming of risk pools, upcoding, and skimping on necessary care are direct consequences of the incentives inherent in paying for health care via capitated fiscal intermediaries, including Medicare Advantage plans, as well as Medicaid Managed Care plans, Accountable Care Organizations, ACO REACH, and other forms of so-called “value-based” payment. Research has shown time and time again that use of capitated fiscal intermediaries raises cost, interferes with care and care coordination, and leads to adverse patient outcomes.

When providers of care are paid directly by Medicare with fee-for-service, or if hospitals (or a hospital with an affiliated physician group practice) were paid with global operating budgets with professionals paid with salaries (without capitation, pay-for-performance, or incentive bonuses), then there would be

no shifting of insurance risk onto providers, no risk pools to game, no upcoding because there would be no reason for risk adjustment and no linking of diagnosis to payment, and no incentive to deny necessary care. Global budgeting of hospitals without “value-based” overlays would be incentive-neutral and would not introduce incentives to either over-treat or under-treat.

We believe a universal single-payer system could be designed to markedly reduce opportunities for fraud and abuse compared to what we have been seeing in the Medicare Advantage program. CMS has a duty to protect and defend Medicare, but the presence of fiscal intermediaries is undermining the program. Capitation was assumed to introduce better incentives than fee-for-service, but experience with MA has shown it to be fertile ground for gaming, fraud, and abuse. We urge CMS to consider simpler, more incentive-neutral, and less administratively burdensome payment systems for reform that could actually achieve the “triple aim” goals: improved quality of care, improved population health, and reduced cost. A properly designed universal and improved version of Traditional Medicare could achieve these goals.

Sincerely,

A handwritten signature in black ink, appearing to read "Philip Verhoef". The signature is fluid and cursive, with the first name "Philip" and last name "Verhoef" clearly distinguishable.

Philip Verhoef, M.D., Ph.D.
President, Physicians for a National Health Program

References:

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https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_v3_SEC.pdf
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